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THE
Hampden Hippocrat

JANUARY—FEBRUARY 1993

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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From the Editors

The Pioneer Valley will soon have an Emergency Medicine Residency Program. Our contributors bring us up to date on the nature, scope, and history of this rapidly growing specialty. Tim Emhoff contributes a thoughtful and revealing article on seatbelts.

Occassionally an article is submitted which doesn't get published. This is not always your editors' fault. The magazine has a limited number of pages, requires advertisements, and has certain "obligatory" articles. The remaining space is agonized over by our publisher, who labors mightily to cram the contributions into the space that is left. We try to eventually publish all articles received, unless they are offensive, illiterate, scurulous, or boring, and sometimes even then. ■

Brigid Glackin, M.D.
Donald J. Higby, M.D.
Co-editors

Hampden Committee Activities

David M. Chadbourne, M.D., brings us up to date on recent activities of our society.

The Executive Committee met in October and November to review reports received from some of our various committees.

The Public Health Committee has compiled the following list of Public Health Topics they feel our membership should consider and make recommendations on:

1. Mandatory seat belts for all ages.
2. Tougher no smoking regulations across the state.
3. Unintentional injuries—falls in the home by elderly—making the home safe or accident prevention suggestions.
4. Gun control.
5. New TB (Tuberculosis) strain and the reappearance of TB in our society.
6. Nutritional imbalance in our society and how it affects our elderly and our children.

The Committee also discussed the possibility of press releases being generated to help bring public health messages to the media.

Dr. Riley suggested that a Grand Rounds be done at area hospitals on the subject of smoking cessation. They may help to reach the physician population.

The Medico-Religious Committee has chosen the topic of Euthanasia for their Ninth Annual Medical Ethics Forum. The seminar will be held on October 20, 1993 at the DeLiso Center of Mercy Hospital. The committee was asked to give thought to names of people who would speak on this topic.

The Credentialing Implementation Committee met in November with area hospital representatives. It was decided that the hospitals would mail their reappointment forms on the physician's birthday when he gets his renewed license. Each individual hospital would take whatever time their institution needs to complete the process. In this way, the physician would receive the reappointment forms all at the same time.

The Health Care Acces Task Force has met with members of the Springfield Museum and Springfield School Department. We would like to help them set up a communication program which would bring information to students on infant mortality, low birth weight and teenage pregnancy. They are still working with the Infant Mortality Grant and Springfield Public Health Commissioner, Dr. Delores Williams. Commissioner Williams is planning an Infant Mortality Summit for the first part of next year. ■

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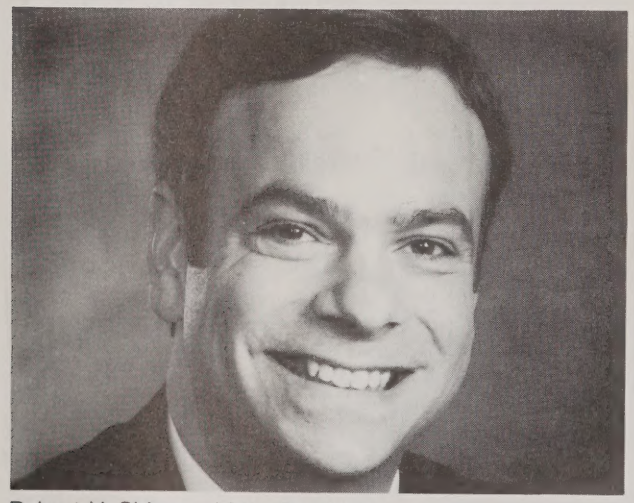
A large part of what we, the Hampden District Medical Society, will be focusing our resources on in the near and far future will be public outreach and education, for the purpose of disease prevention. So many of the ills that beset the public are actually self-inflicted, and as such are eminently preventable. In so doing, we will be actively pursuing the recently enumerated program priorities of the MMS, on the scale of Hampden County.



Robert V. Chircop, M.D., President

Our work on stopping tobacco use started over two years ago, with the annual Anti-Smoking Poster Contest in the Springfield Public Schools. This Spring the contest will expand to all the 3rd grades in Hampden County, and Hampshire County as well. The Hampshire District Medical Society has joined us in this effort, and of course none of it would be possible without the very generous support of our major corporate sponsor, the Marion Merrell-Dow Corp. The contest effort may need a few volunteers to assist with logistics, poster judging, and the like, so please be ready to sign on.

We're also working on the regulatory front to deter smoking. As you know, this past Fall we wrote to the Boards of Health in Hampden County encouraging them to prohibit smoking in public restaurants, etc. I attended a meeting with the Boards in early December to reiterate that message. By and large the Board representatives attending all supported the concept of smoke-free restaurants, and are now initiating the process. It seems even the restauranteurs support the move, as long as it's done regionally. With a little luck, all restaurants in the Pioneer Valley will be smoke-free before the end of 1993. The large impetus behind this issue is the mounting scientific data that secondhand tobacco smoke is not only a nuisance, but also a direct cause of large numbers of deaths from lung (and other) cancer and from heart disease in the U.S. every year. The Boards may also pursue tobacco vending machines and other related issues.

What may prove to be the most influential development in our campaign against tobacco this year was the passage of Question One in November. This was an initiative by the American Cancer Society here in Massachusetts, supported heavily and enthusiastically by MMS. Besides being a welcome encouragement of our political efforts, the affirmative vote establishes a large fund, as much as $120 million annually, to support education on tobacco abuse. This should accelerate the decline in tobacco use in our state immensely.

Still more "outreach" and "public education" is in the immediate planning stages. Here I'm referring to a television "House Calls" program this Spring on tobacco abuse, broadcast live from Springfield. We will need members from several fields to participate in the program and planning, so once again be ready to join in. Having participated in the Cardiology "House Calls" program in the past, I can personally

guarantee the experience is not only painless, but very enjoyable. I'm also referring to plans for members to make presentations in the Springfield schools, with question-and-answer sessions, utilizing cable links already in place there. Topics will vary, but will include AIDS, sexually-transmitted diseases, infant mortality, substance/tobacco abuse, domestic violence, etc. We will need members to volunteer for this also; a very eager and attentive audience awaits you!

Already out of planning and into production, our Public Health Committee has developed and released its first in a planned series of educational messages to the local media, on the subject of alcohol-related trauma. Subsequent messages are planned every month or two. In closing these remarks, I wish to re-emphasize that myriad opportunities exist locally for HDMS to contribute to the "health and welfare of the Commonwealth." The Districts of Hampshire, Franklin, and Berkshire Counties will undoubtedly find the same is true in their respective communities. Our members, Committees, and staff have already worked long and hard to develop these listed above. All we need now are a few good women and men with the mettle. ■

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Prehospital Care in Hampden County

John Santoro, M.D., Chief of Emergency Services at Baystate Medical Center, discusses prehospital care in the region.

"Load and Go" is dead and gone. No longer do "ambulance drivers" pick up victims on the side of the road, scrape them into an ambulance and rush them to the nearest "emergency room". Our pre hospital care system has become much more regulated, complicated, and sophisticated. Our pre hospital care providers have truly developed into the eyes, ears, and hands of our emergency departments.

"The prehospital care system can come into conflict with the private physician."

Let's begin with a little background. Massachusetts is divided into six Emergency Medical Services (EMS) Regions. Hampden County is in Region I, and is the largest geographic area in the state. Each region is further subdivided into areas. Most of Hampden County is in Area III. Every region is run by an Executive Director and a Regional Council. Each area has equal representation on the council, and all members serve in a volunteer capacity. In addition to this, there is a Physician's Council, made up of physicians from around the region who sit as an advisory group to the Regional Council.

I realize that this may all seem pretty boring, but it is important to know where some of the rules and regulations that affect all EMT's come from. One of the main responsibilities of the Regional Council is to develop and implement pre-hospital protocols. These cover everything from the evaluation and treatment of patients to DNR orders in the field. The Regional Council is also responsible for Trauma Center designations as determined by pre-established criteria.

On a statewide level, the Office of Emergency Medical Services (OEMS) is the headquarters of the regional offices and is under the jurisdiction of the Department of Health. The emergency medical technicians (EMT's) have also changed a great deal over the years. There are basically three levels and a few permutations to remember. A Basic EMT (EMT-B) can assess a patient, perform basic CPR and first aid and transport to the hospital. An Intermediate EMT (EMT-I) can do all the above, but also start IV's, intubate (ET tube or EOA) and apply MAST trousers. A Paramedic (EMT-P) can do all the above and in addition is able to give medication (IV, PO, IM) defibrillate, cardiovert, and if appropriately certified, do special invasive procedures. A "first responder" is usually a fireman or policeman who is the first person on the scene and is skilled in first-aid and CPR. Some Basic and Intermediate EMT's are certified in the use of automatic or semi-automatic defibrilators. When indicated, they are able to perform this function.

The pre hospital care system often interacts with the private physician. Most times this is only in the transport of their patients, but sometimes it is more involved. Over the past seventeen years that I have been in emergency medicine, I have noticed two specific situations which have caused conflict and concern to the community physician.

One scenario involves the physician who stops at the scene of an accident to lend assistance. It is often difficult for him or her to understand why the EMT's are not following their directions. It is important for the physician to understand that all pre-hospital care providers operate under standard protocols. Even more important than that, the EMT's are responsible to, and communicate with, the medical control physician through our C-Med radio system. A physician on the scene is usually a welcome addition to provide pre-hospital care. Communication with the Medical Control

physician will usually result in the transfer of responsibility to the on scene physician. The only requirement is that this transfer take place and the on scene physician accompany the patient and pre-hospital care crew to the hospital to transfer care back to the on line medical control physician. It is this medical control physician who is ultimately responsible for the care that is delivered in the field, and any liability associated with it. This situation should not develop into one of conflict, but should be one of mutual professional aid.

The second scenario that sometimes causes difficulties involves the patient who the community physician declares to be a DNR. Again, this situation is clearly defined in the regional protocols. Again, the EMT's are under the guidance of the medical control physician. In order for an EMT to not perform CPR on a patient they are transporting, a valid, current, and written DNR order must be sent with the transporting crew. A verbal order will not suffice. Once again, this problem can usually be resolved by a simple discussion with the medical control physician in the emergency department.

A somewhat related topic which all physicians must guard against is loose talk in front of patients. I have heard physicians openly ask EMT crews "what took you so long", "why did you give that medication", and "are you sure that was the patient's blood pressure". Clearly, these are all appropriate questions, but ones that should be delivered professionally and privately. If any physician or any patient has any questions concerning the pre-hospital care treatment of a patient, they can have the case thoroughly reviewed by asking either the carrier or the medical control hospital.

Indeed, the pre-hospital care system has changed greatly over the years. EMT's now begin the emergency department treatment of patients in the field. They provide equal access to all citizens of the Commonwealth and they have developed into a professional organization that deserves our admiration. They practice medicine in the toughest environment of all and often risk their own safety to do so. They are a group of dedicated professionals who truly deserve to be treated as such. ■

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Emergency Medicine

Mark R. Salzberg, M.D., is the Chairman of the Department of Emergency Medicine at Baystate Medical Center. In the following he reflects on the development and future of this young specialty.

During my final year of medical school (1976) I decided I wanted to pursue a career as an orthopedic surgeon. It made perfect sense to me. I was addicted to skiing and I would no doubt practice in a ski area allowing me to combine my avocation and vocation. To that end I began a surgical internship in Seattle. July 1, 1976 was my first rotation in the emergency department; a 40 year old man came in complaining of a sore throat. I saw him and presented my findings to my attending. The patient was discharged on penicillin with a presumptive diagnosis of strep pharyngitis. Four hours later the patient returned in severe respiratory distress and within two minutes of arrival stopped breathing. It was dinner time and I was alone in the emergency department and all I could think of doing was an emergency tracheotomy. I took a scalpel that was nearby, made what I now know was a sloppy, but successful, tracheostomy incision and at that point the code team arrived and took over. The patient was successfully intubated through his tracheostomy site. He survived his hospitalization, although he did lose several units of blood due to my having cut his thyroid artery. Imagine, epiglottitis in an adult! It was at that point, just 16 hours into my first day as an intern, that I realized that the emergency department was a very special place and one in which I wanted to practice. At the completion of my internship I joined a group of physicians working in Western Massachusetts covering emergency departments. I spent a year as an emergency department attending in hospitals from Athol to Pittsfield and Ludlow to Ware, and discovered I thoroughly enjoyed what I was doing.

"Emergency Medicine has a unique body of knowledge"

In 1977 there was no specialty of emergency medicine that was recognized by the ACGME. In spite of that there were 12 residency programs in emergency medicine in the United States. I applied to and was accepted at the Albert Einstein College of Medicine emergency medicine residency program and began on July 1, 1978. In November of 1979 the ACGME approved the formation of a conjoint board of emergency medicine. It was an eventful day for emergency medicine to be recognized as a true specialty.

In August, 1992 I assumed the position of Chairman of Emergency Medicine at Baystate Medical Center. Baystate Medical Center is placing itself on the cutting edge of emergency medicine. It has always provided first rate care for the patients of western Massachusetts, northern Connecticut, eastern New York and southern Vermont. During 1992 Baystate received approval from the RRC in emergency medicine to begin an emergency medicine residency and we will be welcoming our first group of residents into the new Baystate Emergency Medicine Residency on July 1, 1993. This approval was based on the quality of the emergency department attending faculty and is a continuation of Baystate's commitment to medical education and its recognition of the specialty of emergency medicine.

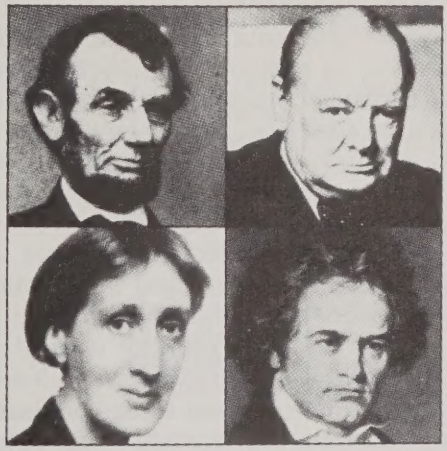
Since 1978, when I began my residency, the field has flourished. There are currently 96 emergency medicine residencies in the United States. We produce approximately 600 emergency medicine specialists per year through these residencies and we expect to see by the end of the decade well over 100 programs. This, however, does not come close to meeting the needs of society or hospitals. At the present time there are approximately 6,000 board certified specialists in emergency medicine. However, there are more than 5,000 hospitals that have active

emergency departments in the United States plus an untold number of freestanding emergency departments and ambulatory care centers that offer practice opportunities for emergency medicine specialists. Therefore, it is reasonable to assume that for the forseeable future there will be a shortfall of qualified residency trained, board certified hospitals with active emergency departments. Baystate's designated to not only educate young physicians in the field of emergency medicine, but help enrich the manpower supply of this very much needed specialty.

Emergency medicine has a unique body of knowledge. One of the most attractive parts of emergency medicine to me was that it very much reminded me of what it was like in the 1950s while I was growing up. When I'd get sick my family doctor stitched my eyebrow, took out my appendix, set my broken bone, took care of my father's heart attack and truly served as the "family doctor." Emergency medicine specialists are trained to deal with life threatening emergencies that cover the entire spectrum of disease, trauma and pathology. We have to be able to effectively communicate with the specialists on their own terms so that when we ask for a consultation we can speak with an authoritative voice. We need to know the emergencies that each specialty has within itself—the hematology/oncology patient who might be in nadir sepsis, the obstetric patient who might have placenta previa, the cardiology patient who needs thrombolysis, the trauma patient that needs resuscitation, the pediatric patient who's dehydrated, plus the myriad of things that can and do happen to people.

Emergency departments have become the safety net for society. There has been a tripling of visits in the last 15 years to emergency departments across the county. Part of the reason is access to medical care. As the population ages and we see more medically indigent patients, the emergency department serves as a primary care focus for those patients. This places an undue strain on facilities already overtaxed and we have had to formulate strategies to triage patients from the main acute emergency departments to our less acute urgent care/fast track areas.

It is an exciting time for emergency medicine and it is certainly an exciting time for the hospitals that have embraced this speciality. We believe we can offer a service to the community that has been sorely missed before and it is exciting to be able to be at the center of this wonderful academic growth. ■



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The Newly Approved Residency Program in Emergency Medicine

Stephen J. Playe, M.D., is the director of the newly created Emergency Medicine Residency program at Baystate Medical Center.

Baystate Medical Center is delighted to announce the beginning of a newly approved residency program in emergency medicine to begin in July 1993. Ours will be the third in Massachusetts and the fourth in New England. We are proud to have received approval by the Residency Review Committee in Emergency Medicine (RRC-EM) on our first application because only one of ten first time applications are approved. This approval is a tribute to a dedicated emergency medicine faculty, farsighted department leadership, universal support from all of the clinical departments, a wealth of clinical material in our emergency department, a mutually supportive relationship with the many referring community physicians and an institution truly dedicated to medical education.

"Only one in ten first time applications are approved."

The application process to establish an emergency medicine residency is arduous. Since emergency medicine is a specialty of great breadth of knowledge and skills, training programs must rely heavily on other academic departments within the institution. In addition to seventeen months of training in the emergency department our residents will complete rotations on other services including trauma, critical care, obstetrics and gynecology, pediatrics, medicine, anesthesiology, surgery, and psychiatry. The RRC-EM requires specific documentation of support from all of these services. Our application included twenty-two letters of support and signed memoranda of understanding with service chiefs that specific educational objectives can be met while our residents are on rotation. Our application ultimately was two hundred and fifty pages long, and the RRC-EM commended us on being so succinct!

The goal of the emergency medicine residency program at Baystate Medical Center is to enable our eighteen residents (six in each of the three years of training) to become expert practitioners of emergency medicine, and to advance the development of the specialty of emergency medicine. Specifically, our curriculum is designed to ensure that our graduates will be able to provide expert triage, evaluation, recognition, resuscitation, and stabilization of acutely ill or injured patients, prioritize urgent and non-urgent evaluation, provide excellent treatment and arrange follow-up care.

Our graduates will assume the role of expert in fields specific to emergency medicine (pre-hospital care, disaster planning, environmental emergencies, wound care, toxicology, injury prevention, and resuscitation), provide on-line leadership in the operation of an emergency department; plan, develop, manage, and improve pre-hospital care systems; effectively educate health care providers and the public in appropriate aspects of emergency medicine; and evaluate new data and monitor clinical practice accordingly. Our graduates will learn to demonstrate the interpersonal skills necessary to establish satisfying professional relationships with patients, colleagues, and members of the community; to maintain physical and mental health through our program of physician wellness; and to contribute to the expanding body of scientific emergency medical knowledge.

We are delighted to be taking this exciting new step to promote emergency medical care and the specialty of Emergency Medicine. We look forward to the continuing support of the medical community of Western Massachusetts as we together strive to provide increasingly excellent care to all of our fellow citizens. ■

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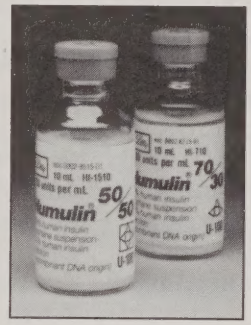

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Seatbelts: This Is Why We Should Wear Them

Timothy Emhoff, M.D., is the Director of Trauma Services at Baystate Medical Center. The following summarizes the recent study by Dr. Emhoff and his team.

Injury is the leading cause of death and disability for Americans from the age of 1 through age 44. Annually 150,000 people will die with another 300,000 sustaining permanent disabilities. Motor vehicle crashes alone will account for 43,000 deaths.

We have all heard that "seatbelts save lives", but do any of us, who haven't been in a serious car crash, really believe that? The Trauma Service at Baystate Medical Center is responsible for the care of anyone sustaining a life or limb threatening injury with the majority being involved in some type of vehicular crash. Part of our job is to maintain accurate records on each patient we treat, both to track trends and as a quality assurance tool to maintain a high level of care. We decided to look back at our own experience here in Western Massachusetts and see if seatbelts really do play a role in death and disability. The results are frightening if you don't wear your seatbelt, but comforting if you do.

"We no longer refer to motor vehicle 'accidents'."

We reviewed the data on 745 patients who were brought to Baystate Medical Center from 1990 to 1991 and were seen by the Trauma Service because of the severity of the car crash or because of the seriousness of the injuries sustained. Of this total only 101 or 14% were wearing seatbelts at the time of the crash. Fully 86% were not wearing some type of restraint! These numbers take into account both drivers and passengers. Just as concerning 54% were drinking with 42% having alcohol levels above 100 mg%. At levels of 50 mg% one can start to show definite impairment, especially for motor skills (like driving a car), while 100mg% is the "legal" level here in Massachusetts. The conclusion is clear: irresponsible people (who don't wear seatbelts) do irresponsible things (drink and drive). Of those who were wearing seatbelts, 72% had no alcohol detected (responsible people usually act responsibly).

When one looks at medical care: who is admitted to the hospital, who stays the longest, who goes to the ICU, etc., it becomes clear that wearing a seatbelt is your best insurance policy. Of 449 people admitted following a car crash, 398, or 89% were unbelted; 51 or 11% were wearing seatbelts! In two years only 11 patients (2%) were hospitalized for two weeks or longer who wore their seatbelts, whereas 77 (17%) unbelted patients stayed for two weeks or longer. If you then look at ICU usage the medical costs of not wearing a seatbelt become even more staggering. A total of *119* unbelted versus only *11* belted patients were admitted to the ICU. Only *one patient* in two years who was wearing a seatbelt had an ICU stay of two weeks or longer. Unbelted drivers/passengers consumed over *700* bed-days in our ICU those two years, versus only *80* by those wearing seatbelts. When one considers the fact that patient charges for a single day in the ICU runs an average of $5100.00 it should be no surprise that insurance costs are high. That "Personal Injury Protection" on your automobile insurance policy doesn't go very far at that rate; guess who pays the rest?

Granted, these 745 patients represent a select population; only those involved in serious crashes (associated with high speed, long extrication, severe deformity of the car) or who exhibited signs of serious head, chest or abdominal injuries at the scene of the crash were referred directly to the Trauma Service. What about all those "fender-benders" that are "treated-and-

released" from the ER? Those numbers we can only guess at because no one collects that data. We don't know what that larger figure is: how many *total* patients are seen in our Emergency Department and how many of those were wearing seatbelts. I suspect not very many. As a state, Massachusetts ranks at the bottom of the list for seatbelt use. Part of the reason for this is that we have no seatbelt law. In states where use of seatbelts is mandated by law usage rates are much higher, and they are saving lives. There is a bill being considered, once again, to require seatbelt use, but if passed, will only be weakly enforced. "Points" will be added to your driving record only if you are in a crash and found not to be using your seatbelt: enforcement "after-the-fact".

If nothing else is concluded from these figures, for those of us who act responsibly: wear our seatbelt, don't drink and drive and drive within the speed limit, the "chances" we'll be seeing you on the Trauma Service are very small. That's why we no longer refer to motor vehicle "accidents": these are not acts of God, no one just "loses control" of the car and ends up a statistic in our trauma registry. These "crashes" are predictable events which follow risky, dangerous behavior, much like any other disease we see on a day-to-day basis. Learn to protect yourself and take out that extra insurance policy: wear your seatbelt! ■

In Memoriam

John F. Rampone, M.D., passed away December 2, 1992. Dr Rampone is remembered by one of his former students in an article in this issue.

David Goldberg, M.D., passed away August 21, 1992. He was an orthopedic surgeon, on the staff of Baystate Medical Center for 46 years. Dr. Goldberg graduated from Tufts University and served in World War II as an army major. He was a member of the American Board of Orthopedic Surgery, and several other medical organizations. He is survived by his wife Thelma, and two daughters.

Rene Hebert, M.D., passed away on September 19, 1992. He practiced general surgery in the area from 1950 to 1985. A graduate of McGill University in Montreal, he served in the Army during World War II. He leaves his wife, Claire, a son and a daughter. ■

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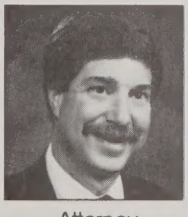

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A Public Health Problem

The author, H. Douglas Barnshaw, M.D., is in the private practice of Psychiatry in Springfield, and Associate Clinical Professor of Psychiatry at Tufts University.

Studies show that 18-23% of women and 8-11% of men will have a major depression at some point in their lives. (1) At any time 3% of the population is suffering from major depression. (2) Depression increases hospital stays, morbidity and mortality of physical illnesses. The biggest tragedy is the 15% that go on to commit suicide.

"At any one time, 3% of the population is suffering from major depression."

Of those that seek care 80% go to their primary physician. Often depressed patients will present with somatic symptoms which must be investigated. Vague complaints such as fatigue, headache, constipation and insomnia should increase the clinician's suspicion of depression. Other patients may focus on the anxious symptoms of irritability, worry and nervousness. Asking about the biological signs of anorexia, anergia, anhedonia, insomnia as well as hopelessness, loss of self esteem and suicidal thoughts will help to clarify the diagnosis. Having people fill out the Beck Scale* can facilitate this survey.

Although much progress has been made in the treatment of depression it remains a chronic relapsing illness for most patients. Only 40% of patients who begin treatment, finish and remain symptom free for two years. (3) Fifty percent of patients relapse after one year, and seventy percent by four years. (4) Increased frequency of depression increases the risk of another episode.

While most depressed patients are seen by primary care physicians, studies have documented that one third to one half of these patients are not diagnosed; of those that are 20-60% drop out of treatment in three weeks, and as low as 11% end up receiving adequate treatment. (5) Side effects of the medications are a major cause. Use of the newer antidepressants should reduce this problem, but the cost is higher. Psychotherapy is needed to increase compliance, to give support while the medication is taking effect, and to identify intrapsychic and interpersonal causal or exacerbating factors in order to prevent relapse. Referral to a mental health professional may be appropriate.

The new medications Prozac and Zoloft can be given once a day and have less of the troublesome side effects of the older antidepressants, which may increase compliance. But they can provoke gastrointestinal symptoms and increase nervousness. It should be remembered that while one antidepressant may work better than another for an individual, at this time there is no way to predict which one that is, and all antidepressants are equally effective. In complicated or unresponsive depression consultation with a psychiatrist is indicated. Combining antidepressants, adding tranquilizers, lithium or thyroid hormone can be helpful in certain patients. Electroconvulsive Therapy remains the most effective treatment for psychotic depression and the very severly depressed patient, particularly if suicidal.

Although difficult and time consuming, treatment of depression can be successful which prevents both further depressions and increased morbidity of physical syndromes, gratifying both the physician and the patient. ■

(1) American Psychiatric Ass., Diagnostic and Statistical Manual of Mental Disorders, 3rd Ed.; Washington, D.C.; Am. Psyciatric Ass. 1987.
(2) Katon, W, et al; Adequacy and Duration of Antidepressant Treatment in Primary Care; Medical Care, Jan. 1992; 67-76
(3) Evans et al; Arch. Gen. Psychiatry 10/92; 801-807 Differential Relapse Following Cognitive Therapy & Pharmacotherapy for Depression
(4) Keller, Martin; Diagnostic Issues & Clinical Course of Unipolar Illness; Review of Psychiatry, Vol 7, '88, A.P.A. Press; 188-209
(5) Ibid Katon, W et al

*Available on request from the Medical Society Office

New Members Welcome

Yared Aklilu, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: September 9, 1962
Premed: George Washington University 1980-1985
Medical: University of Maryland Medical School 1987-1991
Internship: Baystate Medical Center 1991-1992
Residency: Baystate Medical Center 1992-Present
Specialty: Internal Medicine/Pediatrics
Resident

Mary C. Banda, M.D.
444 Montgomery Street
Chicopee, MA 01020

Born: May 29, 1959
Premed: Cheyney State University, PA 1980-1984
Medical: Pennsylvania State University 1986-1989
Internship: Pennsylvania State University Hospital 1989-1990
Residency: Pennsylvania State University Hospital 1990-1992
Specialty: Internal Medicine

Michael J. Daly, M.D.
299 Carew Street #223
Springfield, MA 01104

Born: August 1, 1950
Premed: University of California, Berkeley 1970-1972
Medical: Faculte de Medicine, France 1973-1981
Internship: Baystate Medical Center 1981-1982
Residency: Baystate Medical Center 1982-1985
Fellowship: Children's Hospital, Buffalo, NY Pediatrics
Specialty: Anesthesiology

Mark J. Hotchkiss, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: June 2, 1964
Premed: Duke University 1982-1986
Medical: State University of New York-Stonybrook 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-Present
Specialty: Internal Medicine
Resident

Gary P. Jacobson, D.O.
691 College Highway
Southwick, MA 01077

Born: October 25, 1958
Premed: University of Maine 1977-1981
Medical: New England College of Osteopathic Medicine 1984-1988
Internship: Michigan Health Center, Detroit 1988-1989
Residency: University of Massachusetts Medical School 1989-1992
Specialty: Family Practice

Ronald I. Kirschner, M.D.
Baystate Medical Center
Dept. of Emergency Medicine
759 Chestnut Street
Springfield, MA 01199

Born: December 30, 1954
Premed: Wesleyan University, CT 1972-1976
Columbia University, NY 1980-1982
Medical: Albert Einstein College of Medicine 1982-1986
Internship: Bronx Municipal Hospital, NY 1986-1987
Residency: Bronx Municipal Hospital, NY 1986-1989 Internal Medicine and 1989-1992 Emergency Medicine
Specialty: Emergency Medicine/Internal Medicine

Continued on next page

New Members Welcome

Continued from previous page

David B. Mernoff, M.D.
P.O. Box 2250
Springfield, MA 01101

Born: May 20, 1958
Premed: State University of New York 1976-1980
Medical: New York University School of Medicine 1980-1984
Internship: NYU Medical Center / Bellevue Hospital 1984-1985
Residency: Albert Einstein College of Medicine Hospital and Bronx Municipal Hospital Center 1985-1989
Fellowship: University of Pittsburgh Medical Center and Presbyterian University Hospital 1989-1990
Specialty: Diagnostic and Interventional Radiology

Bruce M. Meth, M.D.
2150 Main Street
Springfield, MA 01104

Born: February 28, 1956
Premed: Harvard College 1974-1978
Medical: New York University School of Medicine 1978-1982
Internship: Naval Hospital, San Diego, CA 1982-1983
Residency: Naval Hospital, San Diego, CA 1984-1986
Fellowship: National Naval Medical Center, Bethesda, MD 1986-1988
Specialty: Internal Medicine/Pulmonary Medicine/Critical Care

Donna M. Polk, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: October 27, 1963
Premed: Washington University, Missouri 1981-1985
Medical: University of Vermont Medical School 1988-1992
Internship: Baystate Medical Center 1992-Present
Specialty: General Surgery
Intern

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John F. Rampone, M.D.

Charles Cahill, M.D. is in the private practice of Obstetrics and Gynecology in Springfield.

John F. Rampone, M.D., died most unfairly at age 53 on December 2nd, 1992. He was born in Providence, Rhode Island, graduated from Providence College in 1961, and received his M.D. Degree from Marquette University School of Medicine (now called the Medical College of Wisconsin) in 1965.

He interned at the Rhode Island Hospital, completed his Ob-Gyn residency at Johns Hopkins University, and continued on to complete his fellowship in Gynecological Oncology at Duke University and the Norwegian Radium Hospital in Oslo. He served in the Army Medical Corps during the Vietnam War where he received a Bronze Star.

He was a member of the Bayard-Carter Society of North Carolina, the Boston Obstetrical Society, the Hampden District Medical Society, and the Massachusetts Medical Society.

He leaves his wife, Paula, his son, John and his daughter, Lisa.

Jack came to Springfield in 1977 where he was the first director of the Gynecological Oncology Department at Baystate Medical Center until 1984. During these years scores of Ob-Gyn residents (myself included) benefited from his wisdom and technical skill, and the gynecologists on the staff of the Old Wesson Women's frequently took advantage of Jack's expertise for both hallway consultations and intra-operative assistance. Those who were advantaged most, however, were his patients: patients with cancer; patients who needed a difficult gynecologic procedure; patients who needed compassion.

As a lecturer, Jack could mercifully condense an hour lecture into 45 minutes of clinical pearls which issued forth like money from an ATM. As a consultant, he would emphasize what you had done RIGHT, while helping you pull your foot out of a surgical cow-pie. A politician he was not.

In his years at Mercy Hospital, Jack continued to give 110%, persistently overcoming a series of afflictions that would have killed a Buick. He would (physically) drag himself into the hospital on some days, and then spend all night in the ICU at the bedside of a patient he had operated on. To the end of his working days, his mind remained clear, his eyes sharp, and his hands skillfully swift.

Jack Rampone spent his last few years living every physician's nightmare, but through generosity of his colleagues (and patients), as many of his needs as possible were provided for. I would personally like to thank Sister Caritas and the Mercy Hospital, the Jewish Nursing Home in Longmeadow, and all those who contributed to the Jack Rampone Fund.

Jack Rampone was the victim of two of the most devastating diseases that can strike a physician: Multiple Sclerosis and Hospital Politics. ■

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Leisure Pursuits

The following is one of the many articles written by anonymous contributors to fill space in the **Hippocrat** *when the regular contributions and advertisements leave too much blank space.*

Doctors are no different than other highly educated professionals in how they spend their precious leisure time. Most physicians have hobbies often to the level of personal obsessions. We thought it might be interesting to see what selected physicians do with their spare time and surplus energy.

Dr. Harley Smoot is a pulmonary medicine specialist who has been in practice for 19 years. It would be difficult for even an observant person to realize that this urbane and nattily dressed specialist is a world-renowned collector of sticks.

"Sticks have played a major role in the development of civilization," notes Smoot. "The aborigines of Australia throw sticks at kangaroos; bundles of sticks are traded for brides in some societies. Sticks are used in Lapland to herd reindeer, and in Saudi Arabia to herd camels. Sticks are relatively easy to come by, and since few people realize their value, they are often thrown away."

Smoot enjoys walking through the woods collecting sticks. He then takes them home, labels them, encloses them in plastic, and hangs them throughout his 24 room mansion which he shares with his pet beaver, "Mike", another stick appreciator.

Bradley Haddock, M.D. a pathologist, is one of the leading practitioners of Kwak Bo Fui, the martial art of Nepal. Haddock has to travel hundreds of miles to participate in competitions and demonstrations of his skills. Currently he holds the green-and-yellow striped belt, the 28th highest rank possible.

Kwak Bo Fui, unlike the other more well known martial arts, is largely defensive. It also relies on guile and quick wits, as well as on well-honed bodily skills.

Haddock was kind enough to demonstrate his art.

"Take this baseball bat," he told us, "and try to hit me with it."

As we raised the bat, he quickly snatched a pair of glasses out of his pocket and pleaded, "You wouldn't hit someone with glasses, would you?"

Momentarily taken aback, we again brandished the instrument. Haddock ran behind a large chair and cowered.

We stalked towards him.

He fell to his knees and began crying for mercy, then, seeing that he was making no impact, rolled himself into a ball whimpering and sniveling all the while.

We did not have the heart to hit him, so we tossed the bat away, whereupon he declared himself the winner of that particular match.

Haddock is interested in starting a Kwak Bo Fui club in this area and invites any interested physicians to call.

"Zip" E. D. Duday, M.D. practices emergency medicine in an area hospital. He got his nickname from his hobby, which is to make zippers. Dudah got interested in zipper making during his residency, when he noted that the clothing of some patients was relatively easy to remove, wheras with respect to other patients, it was almost impossible. He began to notice that this was frequently due to zipper quality. He began to read more and more about the field, and took to visiting factories whenever he had time.

Eventually he purchased a zipper machine, installed it in his garage, and began to make zippers. On a good day he can make 150 zippers an hour.

We asked what he did with all those zippers. He replied that he gave a few away as Holiday gifts, but the majority he kept for himself. Since the zipper machine only turns out one kind of zipper, he does not display them, but rather, puts them in old cardboard boxes which when full, he stores in his attic.

When not making zippers, Dudah tends to his zipper machine, which he has customized with acrylic designs.

"My wife and family left me, I haven't got any friends, and I'm a complete bore," he pointed out in a reflective moment. "What else can I do?"

Ciciley Rimshot, M.D., is a radiologist. Her hobby is training her memory. Rimshot began this in college, and has become so technically skilled that she can remember the exact smell of a locker room she visited twelve years ago. She can recite verbatim the entire Wall Street Journal, not only for today, but for the past month. Her phenomenal talents include the ability to recite the Bible backwards; to take one look at another person, then closing her eyes and concentrating, come up with the exact number of hairs on that persons' head (what a party trick!); to be able to recall the serial numbers on all the dollar bills she has handled during the last year... the list goes on and on.

Rimshot "works out" with her memory for several hours every day, leaving little time for other than the most spartan existence.

"There are compensations," she notes. I've never lost my car keys, I know exactly how much money I have in my purse, and best of all I don't have to constantly worry about who I am and where I live or what day it is, like most people." ■

Isaac Lewin Symposium

The Isaac Lewin Symposium will be held on March 18, 1993, at the West Springfield Ramada Inn. The Symposium will begin at 12:30, end at 5:00, and be followed by a reception. The theme of the program will be breast cancer. All interested physicians and other health care personnel are invited.

Isaac Lewin, M.D., was a dedicated physician who spent much of his career promoting state-of-the-art cancer treatment for patients in Western Massachusetts. Recognizing the need for multi-disciplinary consultation, rapid application of new treatments, and linkage to the larger oncologic community, he was instrumental in organizing the Cancer Cooperative, which was remarkably prescient; the National Cancer Institute "re-discovered" the basic principles in the late '80's. The Cooperative consisted of physicians and nurses in Western Massachusetts who worked in concert with the then Sidney Farber Cancer Center. Clinical trial activity was encouraged; tumor conferences were held, and guest speakers were invited to the area. A regional tumor registry was set up, and the data collected and collated using a primitive computer. It is noteworthy that computerized tumor registries returned to Western Massachusetts (after a 15 year hiatus) in the mid-80's.

Isaac Lewin developed a malignant lymphoma, which ultimately took his life in mid-career. ■

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The Last Word

To the Editors,

I received a copy of the November-December **Hippocrat** today, and send my thanks.

Your invitation to contribute to "The Last Word" opens Pandora's box. I had a "Letter to the Editor" all conjured in my mind, but decided against sending it in because I recalled that during the last business meeting of the Society that I attended there was a complaint from some of the younger physicians that there were too many older physicians around, and that they were not carrying their weight. So when I got home I sent in my resignation from the Public Health and the Medico-Religious Committees on which I had been serving for several years, and from the Society. Thinking about this attitude convinced me that no one would want to hear about my gripe, so I put it out of my mind. I submit the following with some reticence, but not quite enough.

In October I attended the HDMS Ethics seminar, in which the case of an individual dying of leukemia had signed a Health Care Proxy in which he had specified that "under no circumstances" did he want to be put on a machine. It developed that during the course of this anti-leukemia therapy he developed pneumonia. His doctors proposed putting him on a respirator to "get him over the hill", but his wife, who was his designated Agent, being mindful of his specific request, said "No". The doctors persisted, and his wife weakened, and the machine was used. Not one of the panel of "ethicists" thought that this was unethical *(at least not enough to say anything about it; thus they gave it tacit approval).*

During the question and answer period I asked Mr. Leahey, the lawyer who was the expert presenting the case, how one could be MORE specific in his request not to be put on a machine, so that his wish would be honored (after all, the Health Care Proxy is a legal document, and supposedly guarantees a patient the right to say "no" to any treatment via his/her Agent, if he/she is unable to do it). Mr. Leahey did not answer the question, but passed it to Sister McCarthy, one of the panelists, and a member of the Medico-Religious Committee that was sponsoring the seminar. Ms McCarthy did not answer the question asked, but went into a discussion of the special circumstances that made the use of the machine indicated. She ignored the fact that the patient had left written instructions saying "UNDER NO CIRCUMSTANCES".

The day after the Seminar I wrote to Ms. McCarthy and to one other member of the panel (both of whom I knew from having served on the M.-R. Committee) complaining about the non-response to my question, and repeated my question. Up until this time, three months after the incident, I have not been rendered the courtesy of an answer from either of them.

Are these people qualified to hold a seminar on *Ethics*? ■

Lewis W. Whiting, M.D.

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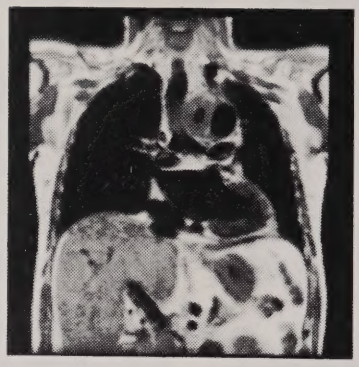

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